14-DAY INJURY REPORT FORM

To be completed when an injured employee has accumulated a 14-day interval of leave due to an on-the-job injury.

Employee:	SS #:
Dept/Div:	Comp #:
1. Date o	f injury# of days lost
	is the last time someone from the employee's department contacted the injured employee?
	and job title of person who last contacted the employee. Job Title:
4. How w	vas contact made?
Emplo	yee telephoned Letter sent by employer
5. What v	was the impression of the employee's condition at the time of last contact?
6. Can yo	ou return the employee to work within 14 days? YES NO
	loyee cannot return to pre-injury work, do you have a modified duty assignment available in epartment?
8. Has the	e condition that produced this injury been corrected?
	then please indicate what steps have been taken to minimize the hazard so that similar ences do not happen in the future?
10. Does y	your department have designated physicians?
Filled out by:	Date:

GUIDELINES FOR FILLING OUT THE 14-DAY INJURY REPORT FORM

Numerous studies have shown that early intervention in a claim with appropriate medical management and vocational assistance techniques greatly reduce the period of time the injured employee is unable to work and the ultimate cost of the claim. This form has been developed by State Risk Management to identify the claims that might benefit from those techniques.

Early identification of those claims allows you to contact the third-party claims administrator (CCIA) and make sure that the proper steps are being taken to offer all services the injured employee might need to help resolve their medical condition and return to their pre-injury job as soon as possible.

This form should be filled out every time an employee has accumulated 14 days of lost time from work due to **ONE** on-the-job injury. In other words, this form should be filled out when an employee has been off work for 2 weeks, again at 4 weeks, and every 2 weeks until the employee returns to work. The lost time days need not run consecutively, but when the employee has been off the job for an accumulation of fourteen days, this form should be filled out and a copy returned to State Risk Management immediately.

Ideally, this form should be filled out by the injured employee's direct supervisor. If this is impossible, the person filling out the form should contact the injured employee's supervisor to obtain accurate and timely information. Whoever fills out this form should be sure to sign it in a legible fashion so that, if necessary, we can contact them to obtain additional information. While the injured employee is off work, weekly contact by the direct supervisor is **strongly** recommended.

The injured employee's Work Comp claim number can be obtained by calling the Colorado Compensation Insurance Authority (CCIA). Their customer service number is 782-4000, or 1-800-873-7242. Please have the accident date and employee's social security number available when you make the call.

Question #5 deals with the employee's subjective reports of his condition. Please state whether the employee feels his condition is improving, worsening or staying the same as when he was injured. Also, please include when the employee had his last doctor's appointment and when the next one is scheduled.

The assistance referred to in question #7 regards setting up a temporary modified duty program in your department. If you would like more information on this subject, just mark the line and someone from Risk Management will be in touch.

If you have any questions regarding filling out this form, feel free to call your loss control representative at State Risk Management. Our number is 303-866-3848.